Important Advances in Clinical Medicine

Epitomes of Progress—Psychiatry

The Scientific Board of the California Medical Association presents the following inventory of items of progress in Psychiatry. Each item, in the judgment of a panel of knowledgeable physicians, has recently become reasonably firmly established, both as to scientific fact and important clinical significance. The items are presented in simple epitome and an authoritative reference, both to the item itself and to the subject as a whole, is generally given for those who may be unfamiliar with a particular item. The purpose is to assist the busy practitioner, student, research worker or scholar to stay abreast of these items of progress in Psychiatry which have recently achieved a substantial degree of authoritative acceptance, whether in his own field of special interest or another.

The items of progress listed below were selected by the Advisory Panel to the Section on Psychiatry of the California Medical Association and the summaries were prepared under its direction.

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Sleepwalking

A REVIEW of the recent literature and several dozen cases of adult somnambulism indicates the following, some of which represent changes from earlier-held views:

- There appears to be no direct association between sleepwalking and dreaming, since the former occurs exclusively during stage IV sleep, that without rapid eye movement (REM). This of course does not question the views of those who attach genetic and dynamic importance to somnambulistic behavior, but merely removes it from the specific category of dream phenomena.
- There appears to be diminishing evidence to link sleepwalking with serious or disabling emotional disturbance. Although there is room for controversy in this area, several studies have indicated normal or near-normal distributions with respect to intelligence, education, social functioning and so forth.
- Consistent with the above, there is increasing evidence that, although pediatric cases appear much more common, somnambulistic behavior can also be easily found in segments (at least) of the young adult population.
- Strong evidence now exists that many if not most sleepwalkers show a possibly causal electroencephalographic "immaturity," an electrical finding which does not seem to correlate with any overt functional or organic abnormality when the person is awake.
- There is little evidence to support the once widely-held association of primary somnambulism with convulsive disorder.
- Past findings of some association of somnambulism with past traumata, enuresis and some other nighttime behaviors, and family histories of sleepwalking are, in general, replicated. Also apparently established is the preponderance of males versus females with the symptom and the finding that children who exhibit somnambulism usually

do not carry it into adult life, either as sleepwalking behavior or as a disabling form of functional disorder.

The various treatments for sleepwalking have covered a wide range of endeavor over the years, including somatic, pharmacologic and psychotherapeutic modalities. The author knows of no studies which show significant numbers of cures in adults, although there are a few anecdotal reports in the literature. One approach which may be promising involves hypnosis and the teaching of arousal cues. Benzodiazepine-based sleeping medications have been suggested because of their ability to specifically decrease stage IV sleep time. In addition, the author has suggested that, because of some of the dynamic and organic similarities to enuresis, tricyclic antidepressants might be studied on an empirical basis. To the author's knowledge, neither of these families of drugs has been explored in this context.

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Technique of Rapid Tranquilization

METHODS TO SAFELY and effectively tranquilize violent, agitated and psychotic patients have recently been proposed in the psychiatric literature. Uncontrolled severe psychomotor agitation and assaultiveness associated with various psychopathological states can result in injury to the patient and others, physical debilitation and exhaustion (life threatening, in some cases of mania and catatonic excitement), and needless prolongation of time spent in hospital. Benefits of providing rapid and safe control of these target symptoms include shorter duration of overt psychosis, briefer hospital stay, lower treatment costs, conservation of nursing care time, less disruption of ward therapeutic milieu, less dependency and regression, and earlier receptiveness to psychotherapy.

Chlorpromazine and haloperidol are frequently selected medications for use in rapid tranquilization; both are potent and proven antipsychotic agents, are safe when appropriately managed and can be dispensed orally and parenterally. The phenothiazine chlorpromazine tends to cause hypotension in susceptible persons, a disadvantage; its sedative effect may be desirable when physical agitation is severe. Haloperidol, a butyrophenone, is less sedating, sometimes an advantage when fear and suspiciousness are factors. Its use, however, is associated with a higher incidence of dystonic reactions than chlorpromazine.

One method suggests simply administering 50 mg of chlorpromazine intramuscularly or 5 mg of haloperidol intramuscularly at 30 minute intervals until adequate control of target symptoms is achieved, followed by establishing an oral maintenance dose. A somewhat more refined method requires that a test dose of 50 mg of chlorpromazine or 5 mg of haloperidol be administered orally after checking vital signs. (Vital signs, especially blood pressure, should be monitored before each dose is given; if systolic pressure is below 90, the dose should be withheld. Hypotension is controlled by supportive measures and withholding medication. Acute dystonia is easily and rapidly relieved with benztropine mesylate [Cogentin®], 1 or 2 mg given intramuscularly.) Doses are adjusted depending on response to the test dose, chlorpromazine being used at 50 to 200 mg given orally each hour and haloperidol at 5 to 10 mg given orally each hour (usually about half the oral dose if given parenterally). Adequate control of symptoms is usually obtained within six to eight hours.

After the desired control of symptoms is achieved, the daily maintenance dose is determined by prescribing two thirds of the twenty-four hour rate in divided doses. For example, if 600 mg of chlorpromazine are required over six hours for control of symptoms, then the 24-hour rate is 2,400 mg; two thirds of this amount in divided dosage would be 400 mg four times daily.

The patient should be allowed to sleep (adequate tranquilization being assumed if patient is asleep), keeping in mind that many psychotic patients come to the hospital following a period of sleep disturbance. Drowsiness associated with antipsychotic drugs predictably diminishes on the third day of use. Psychotherapy can usually be implemented at that time.

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